SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Filing at a Glance

Company: Medical Alliance Insurance Company

Product Name: Medical Malpractice Rule Filing	SERFF Tr Num: IRMS-128131632	State: Illinois
TOI: 11.0 Medical Malpractice - Claims Made/Occurrence	SERFF Status: Closed-Filed	State Tr Num: IRMS-128131632
Sub-TOI: 11.0023 Physicians & Surgeons	Co Tr Num: PPL-12-01-R	State Status:
Filing Type: Rule		Reviewer(s): Gayle Neuman
	Author: Joyce Janowski	Disposition Date: 06/28/2012
	Date Submitted: 02/29/2012	Disposition Status: Filed
Effective Date Requested (New): 03/01/2012		Effective Date (New): 03/01/2012
Effective Date Requested (Renewal): 03/01/2012		Effective Date (Renewal): 03/01/2012

State Filing Description:
routed 3/6/12

General Information

Project Name: Medical Malpractice Rule Filing	Status of Filing in Domicile: Authorized
Project Number: PPL-12-01-R	Domicile Status Comments: IL
Reference Organization:	Reference Number:
Reference Title:	Advisory Org. Circular:
Filing Status Changed: 06/28/2012	
State Status Changed:	Deemer Date:
Created By: Joyce Janowski	Submitted By: Joyce Janowski

Corresponding Filing Tracking Number:
Filing Description:
On behalf of Medical Alliance Insurance Company (MAIC), we are submitting a Medical Malpractice rule filing. This filing is to amend the claims-made rule manual currently on file.
Enclosed please find:
Cover letter
- Explanatory memorandum
- RF-3
- Officer certification
- Actuarial certification

- Schedule rating plan worksheet (internal use only)
- Rule manual

MAIC has internal policies in place for gathering and reporting statistics to the Department of Insurance. As such, we do not report to a statistical agency.

Though this filing amends various rule pages in our claims-made manual as explained in the explanatory memorandum, we enclose the rule manual in its entirety, with the exception of Appendix I which comprises the rate pages for our program and have not been revised. Please note that this filing will be applicable to all new and renewal policies effective on and after March 1, 2012.

Enclosed is authorization for IRMS Actuarial Services to submit this filing on behalf of Medical Alliance Insurance Company. All correspondence related to this filing should be directed to IRMS Actuarial Services. Please advise if you should need any further clarification regarding this filing.
State Narrative:

Company and Contact

Filing Contact Information

Joyce Janowski, Actuarial Analyst	jjanowski@irmsactuary.com
17035 W. Wisconsin Avenue, Suite 105	262-754-1600 [Phone] 14 [Ext]
Brookfield, WI 53005	262-754-1601 [FAX]

Filing Company Information

(This filing was made by a third party - irmsactuarialservices)

Medical Alliance Insurance Company	CoCode: 11861	State of Domicile: Illinois
1151 East Warrenville Road	Group Code:	Company Type: P&C
Naperville, IL 60566	Group Name:	State ID Number:
(630) 276-5400 ext. [Phone]	FEIN Number: 32-0097644	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medical Alliance Insurance Company	$0.00		

State Specific

Refer to our checklists prior to submitting filing (http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm).: Acknowledged

Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: Acknowledged

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABLITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. : http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp .: Acknowledged

Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: Acknowledged

The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": Acknowledged

When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: N/A

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Filed	Gayle Neuman	06/28/2012	06/28/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Gayle Neuman	03/02/2012	03/02/2012	Joyce Janowski	03/06/2012	03/06/2012

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Effective date	Note To Reviewer	Joyce Janowski	06/28/2012	06/28/2012
effective date	Note To Filer	Gayle Neuman	06/28/2012	06/28/2012

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Disposition

Disposition Date: 06/28/2012
Effective Date (New): 03/01/2012
Effective Date (Renewal): 03/01/2012
Status: Filed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document *(revised)*	Manual		Yes
Supporting Document	Manual		Yes
Supporting Document	Schedule Rating Worksheet		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	Filing Authorization Letter		Yes

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	03/02/2012
Submitted Date	03/02/2012
Respond By Date	03/16/2012

Dear Joyce Janowski,

This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:

1. Please indicate if your company has a plan for the gathering of statistics or the reporting of statistics to statistical agencies? If yes, what stat agency is being used?

2. You are required to provide a mark-up showing the exact changes that were made to the manual.

3. How many policies had a schedule rating plan credit or debit in excess of 25% as of January 1, 2012?

Sign up to get e-mail notification for updates to the Department's website. http://insurance.illinois.gov/RSS/

Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:

http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.htm

Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.

Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.

Sincerely,

Gayle Neuman

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/06/2012
Submitted Date	03/06/2012

Dear Gayle Neuman,

Comments:

Response 1

Comments: #1. MAIC has internal policies in place for gathering and reporting statistics to the Department of Insurance. As such, we do not report to a statistical agency.

#2. Attached please find the re-lined version of our manual showing changes made and submitted 02/29/2012.

#3. As of 01/01/2012, 5 policies have a schedule rating plan credit or debit in excess of 25%.

Changed Items:

Supporting Document Schedule Item Changes
Satisfied -Name: Manual
Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please let us know if we can be of further assistance.

Thank you.

Sincerely,
Joyce Janowski

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Note To Reviewer

Created By:

Joyce Janowski on 06/28/2012 09:04 AM

Last Edited By:

Gayle Neuman

Submitted On:

06/28/2012 01:20 PM

Subject:

Effective date

Comments:

This filing was put into effect as of March 1, 2012.

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Note To Filer

Created By:

Gayle Neuman on 06/28/2012 07:59 AM

Last Edited By:

Gayle Neuman

Submitted On:

06/28/2012 01:20 PM

Subject:

effective date

Comments:

The Department of Insurance has now completed its review of this filing. Originally, you requested the filing be effective March 1, 2012. Was the filing put in effect on March 1, 2012 or do you wish to have a different effective date? Your prompt response is appreciated.

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Explanatory Memorandum
Comments:
Attachment:
Explanatory Memorandum.pdf

Item Status: **Status Date:**

Satisfied - Item: Form RF3 - (Summary Sheet)
Comments:
Attachment:
Form RF-3.pdf

Item Status: **Status Date:**

Satisfied - Item: Certification
Comments:
Attachments:
Illinois Certification.pdf
actuary cert.pdf

Item Status: **Status Date:**

Satisfied - Item: Manual
Comments:
Attachments:
Manual of Claims-Made Rules and Rates.pdf
MAIC Manual of Rates-Claims Made 03 01 12 edition w red lining.pdf

Item Status: **Status**

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Date:

Satisfied - Item: Schedule Rating Worksheet
Comments:
Attachment:
Schedule Rating Plan.pdf

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Attachment:
Cover Letter.pdf

Item Status: **Status Date:**

Satisfied - Item: Filing Authorization Letter
Comments:
Attachment:
20120229103847.pdf

MEDICAL ALLIANCE INSURANCE COMPANY

EXPLANATORY MEMORANDUM

PHYSICIANS PROFESSIONAL LIABILITY

EFFECTIVE MARCH 1, 2012

This filing is to revise relevant portions of the rating manual currently on file with the Department of Insurance. The changes, similar to some of those implemented by ISMIE in their 10/01/2011 manual edition, are as follows:

General Rules, Section VIII.C.4. and C.5., Cancellation/Non-Renewal, Extended Reporting Period
Regarding paramedical employees, this rule has been amended to add paramedical employees with separate limits in the verbiage. This language does not reflect a change in application of the rule but rather is added for clarification purposes as paramedical employees with separate limits have historically been handled in the same manner as a named insured physician under this rule.

Appendix II, Section X.E., Loss-Free Discount
This rule was amended to reflect that the discount does not apply to policies with FTE Per Visit Rating as those policies receive the application of a new rule, Section VIII, Loss Experience Calculation, as explained below.

Appendix II, Section XI.A., Schedule Rating Plan
As required by Company Bulletin 2011-05, the schedule rating plan has been revised to limit the maximum credit/debit amount to +/-25%. Additionally, we have removed the Loss Experience category, renamed the Specialty Balance category to Specialty Classification and changed the percentage amount to better reflect the type of components considered, eliminated the Employee Selection, Training, Supervision and Experience category, added a Patient Rapport category, amended the Risk Management Program category to add Quality of Care as an additional component of consideration, eliminated the Unusual Risk Characteristics category and added a Professional Skills and Competency category for consideration.

Appendix II, Section XI.B., Schedule Rating Plan
Given the revision of the plan cap to +/-25%, the combination of schedule rating and the Loss-Free Discount was also amended.

Appendix II, Section XIII. Loss Experience Calculation
This new rating rule has been developed as a result of Company Bulletin 2011-05. Loss Experience was a category contemplated in the previous schedule rating plan. It has been removed from the schedule rating plan and will be utilized for our new and existing business to account for loss experience through the application of a specific formula.

Section 754.EXHIBIT A Summary Sheet (Form RF-3)

FORM (RF-3)

SUMMARY SHEET

Change in Company's premium or rate level produced by rate revision effective 03/01/2012.

	(1) Coverage	(2) Annual Premium Volume (Illinois) *	(3) Percent Change (+or-) **
1.	Automobile Liability Private Passenger		
	Commercial		
2	Automobile Physical Damag Private Passenger		
	Commercial		
3.	Liability Other Than Auto		
4.	Burglary and Theft		
5.	Glass		
6.	Fidelity		
7.	Surety		
8.	Boiler and Machinery		
9.	Fire		
10.	Extended Coverage		
11.	Inland Marine		
12.	Homeowners		
13.	Commercial Multi-Peril		
14.	Crop Hail		
15.	Other Medical Malpractice Life of Insurance	11,269,971	0.0%

Does filing only apply to certain territory (territories) or certain Classes? If so, specify: N/A

Brief description of filing. (If filing follows rates of an advisory Organization, specify organization): Revision of schedule rating plan, addition of loss experience calculation rule.

*Adjusted to reflect all prior rate changes.
**Change in Company's premium level which will result from application of new rates.

Medical Alliance Insurance Company
Name of Company

Carolyn M. Shanahan - Paralegal
Official – Title

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE

I, Edward J. Holzhauer, a duly authorized officer of Medical Alliance Insurance Company, am authorized to certify on behalf of the Company making this filing, after due inquiry of a qualified actuary, that the company's rating rules are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the subject of this filing.

Edward J. Holzhauer

Signature and Title of Authorized Insurance Company Officer

2/24/12

Date

Insurance Company FEIN: 32-0097644 Filing Number: PPL-12-01-R

Insurer's Address: 1151 East Warrenville Road, P.O. Box 3015

City: Naperville State: IL Zip Code: 60563

Contact Person and email: Carolyn M. Shanahan / CShanahan@ihastaff.org

Direct Telephone and Fax Number: 630/276-5659 / 630/717-4787

ILLINOIS CERTIFICATION FOR MEDICAL MALPRACTICE RATES

I, Mark Cain, a duly authorized actuary of I llinois Risk Management Services, am authorized to certify on behalf of Medical Alliance Insurance Company making this filing that the company's rates are based on sound actuarial principles and are not inconsistent with the company's experience, and that I am knowledgeable of the laws, regulations and bulletins applicable to the policy rates that are the subject of this filing.

Mark J. Cain Jr Senior Director, FCAS, MAAA 2-29-12

Signature, Title and Designation of Authorized Actuary Date

Insurance Company FEIN 32-0097644 Filing Number PPL-12-01-R

Insurer's Address 1151 East Warrenville Road PO Box 3015

City Naperville State IL Zip 60563

Contact Person's Name and E-mail Carolyn M .Shanahan CShanahan@ihastaff.org

Direct Telephone and Fax Number 630/276-5659 630/717-4787

MEDICAL ALLIANCE INSURANCE COMPANY

MANUAL OF
CLAIMS-MADE
RULES AND RATES

(Edition Date: 09/01/06)

MEDICAL ALLIANCE INSURANCE COMPANY
PHYSICIAN PROFESSIONAL LIABILITY
CLAIMS-MADE INSURANCE POLICY

MANUAL OF RULES AND RATES

TABLE OF CONTENTS

GENERAL RULES		Page
I.	General Instructions	4
II.	Policy Period	5
III.	Scope of Coverage	5
IV.	Persons Insured	5
V.	General Definitions	5
VI.	Limits of Liability	5
VII.	Rates and Premium Calculation	6 - 8
VIII.	Cancellation / Non-Renewal	8 - 11
IX.	Additional Interests	11
X.	Underwriting Procedure	12 - 13
XI.	Physician Specialty	13
XII.	Supplementary Rules	14
XIII.	Deductibles	14 - 15

(Cont'd.)

MANUAL OF RULES AND RATES

TABLE OF CONTENTS

		Page
APPENDIX I		
I.	Annual Claims-Made Rates	1 - 14
II.	Paramedical Employees Rates	15 - 16
III.	Per Visit Rates	17
APPENDIX II		
I.	Maturity Year Factors	1
II.	Tail Factors	1
III.	Territories	1
IV.	Medical Procedure Definitions	2 - 5
V.	Newly Practicing Physician Premium Discount Rules	5 - 6
VI.	Part-Time Rating Rules	6 - 8
VII.	Free Medical Clinic Coverage	8
VIII.	Suspended Coverage Rules	8 - 9
IX.	Locum Tenens (Additional Insured)	9 - 10
X.	Loss-Free Discount	10 - 11
XI.	Scheduled Rating Credits/Debits	11
XII.	Risk Management Educational Discount Program	12
XIII.	Loss Experience Calculation	12
APPENDIX III		
I.	Medical Corporation	1 - 2

MEDICAL ALLIANCE INSURANCE COMPANY
PHYSICIAN PROFESSIONAL LIABILITY
CLAIMS MADE INSURANCE MANUAL

GENERAL RULES

I. GENERAL INSTRUCTIONS

This manual contains the rules and rates governing the underwriting of professional liability insurance for **Physicians**, **Medical Corporations** and **Paramedical Employees** written on a claims-made policy form.

Additional exposure risks for which coverage is provided on or after the effective date of this manual, either by endorsement of outstanding policies or by the issuance of separate policies, shall be written on the basis of the rates and rules in effect at the time the coverage is provided.

The following requirements shall be observed in the preparation of policies of insurance covered by this manual:

A. On policies issued to a **Physician**, the **Physician** shall be identified as the **Named Insured** on the Declarations Page by name, rating medical specialty and rating code number.

B. On policies issued to **Medical Corporations** whose qualification for said policy is established in Appendix III, the **Medical Corporation** shall be identified as the **Named Insured** on the Declarations Page by its legal name.

C. On policies issued to a group of **Physicians** not associated with a **Medical Corporation**, a non-covered **Named Insured** for the purposes of facilitating the issuance, administration and payment of the policy shall be identified on the Declarations Page.

D. Additional **Insureds** and additional **Named Insureds** (who may be Doctors of Medicine, Doctors of Osteopathy, **Paramedical Employees** or **Medical Corporations**) shall be identified on attaching endorsements either by name (in the case of **Physicians** and a sole shareholder **Medical Corporation**) or by name or number (in the case of designated **Paramedical Employees**).

E. When applicable, policies shall be endorsed to acknowledge any reported exceptions to the representations and warranties stipulated on the Declarations Page.

F. Once a policy has been issued, any changes thereto shall be accomplished by means of endorsement(s).

II. POLICY PERIOD

A. Policies are written for the period of time specified on the Declarations Page upon payment of premium and expire upon cancellation, non-renewal or renewal.

B. Policies are generally written for a twelve (12) month period beginning on the policy effective date.

C. Any policy written for at least a twelve (12) month period may, upon the **Named Insured's** request and approval by **MAIC**, be extended up to a maximum of ninety (90) additional days. The aggregate limit of liability as described in Section VI. shall apply to the sum of the original **Policy Period** plus any extension.

III. SCOPE OF COVERAGE

For details of coverage and exclusions, refer to standard policy.

IV. PERSONS INSURED

For persons insured, refer to standard policy.

V. GENERAL DEFINITIONS

For general definitions, refer to standard policy.

VI. LIMITS OF LIABILITY

Manual rates and minimum premiums are calculated to provide limits of $1,000,000 "Each Person" and a **Policy Period** aggregate of $3,000,000. Unless modified by endorsement, the inclusion of more than one **Insured** under a policy shall not operate to increase **MAIC's** limits of liability.

MAIC may, at its discretion, increase the policy aggregate. The "Each Person" limit may be obtained only in the amount of $1,000,000 with a corresponding annual aggregate of $3,000,000 applied to each **Named Insured**, or an aggregate limit may be shared by each **Named Insured** with the amount being determined by the number of exposures in the group as follows:

Number of Exposures *	Policy Aggregate
2	5M
3	8M
4	10M
5	15M
6	16M
7	18M
8	20M
9	22M
10 – 19	25M
20 – 39	40M
40 - 59	55M
60 – 79	70M
80 – 99	85M

*** For each additional 20 exposures, increase the aggregate by $15M.**

VII. RATES AND PREMIUM CALCULATION

A. RATES

Annual and Extended Reporting Endorsement premiums applicable to **Physicians** for each specialty, territory and maturity year appear on the rate pages contained in Appendix I, Section I.

Premiums and rate categories for **Paramedical Employees** (who may be added by endorsement as either additional **Named Insureds** or additional **Insureds** on the standard policy) appear on the rate pages contained in Appendix I, Section II.

B. (a) RATED RISKS

Every risk described in the rate pages contained in Appendix I, Section II for which the symbol (a) appears in lieu of a specific rating designation and any other risk, risk procedure or technique not otherwise identified or defined in the appendices forming a part of this manual, shall be submitted to **MAIC** for rating.

C. CALCULATION OF PREMIUM

Subject to Paragraph E. below, the premium shall be determined on the basis of the units of exposure existing at policy inception and shall be calculated in accordance with the applicable rates and rules contained or referenced in this manual. A premium involving $.50 or more shall be rounded to the next higher whole dollar. Interim premium adjustments including endorsements shall be calculated pro rata.

D. QUARTERLY INSTALLMENT OPTION

The developed premium is billed on a quarterly basis; 34% prior to policy issuance and 22% prior to the start of each subsequent three (3) month period, and shall be rounded to the nearest whole dollar. There are no interest charges or installment fees assessed. Any additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

E. MINIMUM PREMIUM RULE

Except as provided in Appendix II, Section VII, no Professional Liability Claims-Made Insurance Policy may be issued for less than a premium charge of $400 per year.

F. MATURITY YEAR

Each **Named Insured** shall, each **Policy Period**, have a designated maturity year. The measurement of the maturity year begins on the **Named Insured's Retroactive Date** and advances each subsequent year thereafter until maturity is achieved for those policies that have been issued for six (6) months or more. In the event the policy has been issued for less than six (6) months, the maturity year does not advance. See Appendix II, Section I for maturity factors.

G. FULL TIME EQUIVALENT (FTE) AND PER VISIT RATING

1. FTE/Per Visit rating is based on a certain identifiable pricing mechanism (i.e., "per-patient encounters", "per procedure", "total revenues" or "total hours") in which to assess a premium charge to a **Medical Corporation**.

2. FTE/Per Visit premium is not subject to a premium reduction because of:

   a. Suspended Coverage;
   b. Newly Practicing **Physician** Discount; or
   c. Part-Time Rating.

3. See the rate pages contained in Appendix I, Section III. for Per Visit rates.

4. FTE premium is based on the full-time mature rate of the specialty presented.

VIII. CANCELLATION / NON-RENEWAL

A. BY MAIC

The earned premium shall be determined on a pro rata basis by multiplying the number of units of exposure for the period the policy was in force by the applicable rates.

B. BY THE NAMED INSURED

The earned premium shall be determined as the difference between written and return premium. Return premium will be calculated at 90% of pro rata. The earned premium so calculated shall also be subject to the Minimum Premium Rule in Section VII, Paragraph D. If the **Physician** requests cancellation (written request from **Named Insured** required), reinstatement may not take effect until three (3) months after the cancellation date and will be subject to re-underwriting including the required purchase of an Extended Reporting Endorsement at the time of cancellation. If cancellation is due to death, **Retirement** or **Disability**, the earned premium shall be calculated on a pro rata basis.

C. EXTENDED REPORTING ENDORSEMENT

Refer to Appendix II, Section II for the tail factors to be applied to the annual expiring premium for the purchase of an Extended Reporting Endorsement. Said endorsement may be purchased upon policy termination or upon coverage termination of a **Named Insured** because of severance of the relationship between an additional **Named Insured** and the **Named Insured**. Either the **Named Insured** or the additional **Named Insured** may purchase an Extended Reporting Endorsement on behalf of the additional **Named Insured.**

The purchase of an Extended Reporting Endorsement is subject to the terms and conditions specified in the standard policy. The Extended Reporting Endorsement premium for an individual **Named Insured** is subject to the **Named Insured's** specialty and territory in effect as of the policy termination date.

The Extended Reporting Endorsement premium for a **Medical Corporation** shall be the sum of all applicable individual Extended Reporting Endorsement premiums and any **Medical Corporation** Extended Reporting Endorsement premium as appropriate.

1. **Individual Named Insured**

   Manual Rate (7th Year Rate based upon territory and specialty)

   X Maturity Year Factor

   = Annual Base Premium

   X Part Time Factor (if applicable),

   or

   X Newly Practicing Physician Discount Factor (if applicable),
   (use whichever applicable factor above would provide the greatest discount)

   = Annual Adjusted Base Premium

   - Loss Free Discount (if applicable, Loss Free Discount Factor x Annual Adjusted Base Premium)

   = Annual Discounted Premium (net of loss free discount)

   X Tail Factor

   = Extended Reporting Endorsement Premium

   If the **Named Insured** is on suspended coverage at the date of policy cancellation, the rating factors in effect before the suspended coverage will be used.

2. **Medical Corporation**

   To determine the Extended Reporting Endorsement premium for a **Medical Corporation**, the individual **Physician** premiums that have a premium bearing relationship to the corporation are used. The premium is computed as follows:

   a. For **Medical Corporations** with four or less **Physicians** with premium bearing relationships:

      Using the individual **Physician** rating method, multiply the annual adjusted base premium of each individual **Physician** by a factor of .21 (21%). Then add these amounts together to determine an annual premium.

b. For **Medical Corporations** with five or more **Physicians** with premium bearing relationships:

Determine the five highest rated **Physicians** based upon their annual adjusted base premiums. Add these annual adjusted base premiums together and divide by 5.

_____

= Annual Base Premium

X Tail Factor

_____

= Extended Reporting Endorsement Premium

If a **Medical Corporation** is rated on an auditable premium basis, the annual base premium is determined by multiplying the per exposure rate by the number of exposures. The tail factor is applied to the annual base premium.

c. If **Paramedical Employees** are covered under the policy, add the sum of the individual **Paramedical Employee** premiums to the developed **Medical Corporation** annual base premium before applying the tail factor.

3. All premiums for the Extended Reporting Endorsement are payable as of the due date shown on the Extended Reporting Endorsement invoice. Any such premium not paid as of the due date shall be in default and shall be grounds for not issuing or for canceling the Extended Reporting Endorsement. Any premium received after the due date shall be refunded within ten (10) business days.

4. A **Named Insured** may be granted an Extended Reporting Period without cost in the event of death or **Disability**.

A **Named Insured** who is a **Physician** or **Paramedical Employee** (separate limits) may obtain an Extended Reporting Endorsement at no cost or at reduced cost in the event of **Retirement** (as defined in the policy). Coverage with previous claims-made carriers may, at MAIC's option, be substituted in lieu of **MAIC** coverage so long as the **Physician** or **Paramedical Employee** (separate limits) is insured with **MAIC** for at least one year prior to requesting the Extended Reporting Endorsement. Waiver of the full premium for an Extended Reporting Endorsement based on **Retirement** will be granted only once to a **Physician** or **Paramedical Employee** (separate limits).

A credit toward the purchase of the Extended Reporting Endorsement is computed as follows:

a. one-sixtieth (1/60) of the premium for each full month the retiring **Physician** or **Paramedical Employee** (separate limits) has had consecutive coverage with **MAIC** for up to a total credit of 100% if the **Physician** or **Paramedical Employee** (separate limits) has attained the age of fifty-five at **Retirement**; or

b. one one-hundred twentieth (1/120) of the premium for each full month the retiring **Physician** or **Paramedical Employee** (separate limits) has had consecutive coverage with **MAIC** for up to a total credit of 100%, regardless of age of the **Physician** or **Paramedical Employee** (separate limits) at **Retirement**.

5. A **Physician** or **Paramedical Employee** (separate limits) previously granted an Extended Reporting Period without cost or at reduced cost because of **Retirement** may, in the future, be considered for insurance with **MAIC** under the following circumstances:

   a. Completion of an application for insurance;

   b. Reapplication after twelve (12) months;

   c. Has reported no **Claims** or **Suits** pursuant to the Extended Reporting Endorsement; and

   d. Payment of the appropriate premium for the period the policy was either placed on suspended coverage or rated Part-Time, 20%, Retired, Not in Practice at the same, territory wand maturity year in effect at the time of termination.

6. The premium calculated in Paragraphs 1 or 2 above is subject to proration depending upon the policy termination date and the **Named Insured's** maturity year.

   a. Maturity Year One - The Extended Reporting Endorsement premium shall be computed on a pro rata basis for each day the policy has been in force and shall be rounded to the nearest whole dollar.

   b. Maturity Year Two Through Maturity Year Six - The Extended Reporting Endorsement premium shall be the sum of:

      (i). The pro rated difference between the Extended Reporting Endorsement premium at the end of the current **Policy Period** and the premium that would have been charged had the policy terminated at the end of the preceding **Policy Period**; and

      (ii). The premium that would have been charged in the preceding **Policy Period** if the policy had terminated one (1) year earlier.

   c. Maturity Year Seven - Not subject to proration.

IX. ADDITIONAL INTERESTS

The addition of coverages, persons or entities not provided for in the standard policy shall be submitted to **MAIC** for rating.

X. UNDERWRITING PROCEDURE

A. PHYSICIAN COVERAGE

1. If a **Named Insured** employs a **Physician**, all such employed **Physicians** must be insured with **MAIC**.

2. If a **Physician's** primary office practice and primary hospital practice are in different territories, the territory to be used for rating purposes shall be:

   a. For non-surgical specialties not identified in b. below, the primary office practice location is used.

   b. For surgical specialties including but not limited to those listed below and the following identified non-surgical specialties, the primary hospital location is used.

      Anesthesiology, Cardiovascular Disease (MRP), Emergency Medicine, Family Practice (Not Primarily Major Surgery), General Practice (Not Primarily Major Surgery), Ophthalmic Surgery, Pathology, Radiology.

   c. "Primary" means 51% or more of the **Physician's** total office or hospital practice time, as applicable, spent in a given territory.

3. If a **Physician** practices in two or more territories, or, if hospital-based, the **Physician** practices in two or more hospitals which are located within different territorial boundaries, the higher rated territory shall be utilized for rating purposes.

4. The premium shall be the sum of:

   a. The rate applicable to the individual **Physician's** specialty, territory and maturity year which appears on the rate pages contained in Appendix I, Section I; plus,

   b. The appropriate per person rate for each **Paramedical Employee** whose rate appears on the rate pages contained in Appendix I, Section II; plus,

   c. Any scheduled rating credit or debit.

5. In the event a **Physician's** specialty rating is reduced, no additional premium charge shall be made. However, if the **Physician** terminates the policy within twenty-four (24) months from the effective date of a specialty reduction the resulting Extended Reporting Endorsement calculation shall be made at the highest specialty designation in effect while insured by **MAIC.**

B. MEDICAL CORPORATION COVERAGE

See Appendix III.

C. PRIOR ACTS COVERAGE

1. Prior Acts Coverage is available.

2. The appropriate maturity year will be measured as described in Section VII, Paragraph F.

3. The premium for Prior Acts Coverage shall be calculated as described in Section X, Paragraphs A and B.

XI. PHYSICIAN SPECIALTY

A. **Physician** specialty assignment for rating purposes shall be made on the basis of:

1. The **Physician's** trained medical specialty. "Trained medical specialty" is defined as:

   a. Completion of a bona fide residency program by the **Physician**;

   b. Completion of a bona fide residency and fellowship program by the **Physician**; or

   c. If neither a. or b. are applicable to the **Physician's** specific circumstances, the type of medical practice engaged in by the **Physician**, and how such **Physician** is holding him/her self out to the public.

2. When applicable, performance or non-performance of medical procedures in accordance with the rules contained in this manual.

B. The initial basis of rating assignment shall be the **Physician's** trained medical specialty as described above. To the extent that the **Physician's** practice activity contemplated by the medical specialty may be increased by the performance of medical procedures not usual and customary to the trained specialty, or may be decreased by the non-performance of medical procedures that are usual and customary to the trained medical specialty, the **Physician's** rating assignment may be adjusted higher or lower as specified in Appendix II, Section IV.

C. The **Physician** specialty rating schedules and rules of this manual do not apply to **Physicians** in active United States Military Service or to the government practice activity of **Physicians** employed on a full or part-time basis by any government agency, institution or facility, other than a medical school or student health center.

Physicians and **Medical Corporations** rendering or furnishing medical services within any government-owned or operated institution or facility (except a medical school, a facility owned or operated by a medical school or a student health center) on a fee-for-service (independent contractor) basis shall be subject to (a) rating.

XII. SUPPLEMENTARY RULES

A. SPECIAL RULES GOVERNING PHYSICIAN RATING

1. NEWLY PRACTICING PHYSICIAN PREMIUM DISCOUNT RULE

See Appendix II, Section V.

2. PART-TIME RATING RULE

See Appendix II, Section VI.

3. SUSPENDED COVERAGE RULE

See Appendix II, Section VIII.

4. CHANGE IN SPECIALTY MINIMUM DURATION RULE

Physicians who voluntarily request either a decrease or increase in specialty assignment may not obtain a further change in specialty assignment until a period of three (3) months has elapsed. This rule shall not apply when it conflicts with any other rule in this manual.

5. LOSS-FREE DISCOUNT

Physicians with no indemnity payments over a given experience period may qualify for a premium discount. See Appendix II, Section X.

B. RESTRICTIVE ENDORSEMENT RULE

Whenever a restrictive endorsement is attached to the policy of an employed **Physician, Paramedical Employee** or a **Physician** who is either an officer, director or shareholder of a **Medical Corporation**, a comparable endorsement shall be attached to the respective employer's policy if such employer is insured by **MAIC**. Such endorsement shall serve to limit the liability otherwise afforded under such policies, for the acts and omissions of the **Insured** whose individual coverage is restricted, if the **Claim** or **Suit** arises out of the excluded activity.

XIII. DEDUCTIBLES

A. A deductible may be available to **Named Insureds** who either desire to share in their losses in return for premium savings or have demonstrated a significant adverse loss profile necessitating that they take a primary role in the management of their risk.

B. A deductible requires the **Named Insured** to share financially in each and every **Claim**. Varying amounts may be arranged depending on the financial and risk management expertise of the **Named Insured**. The deductible, which is inside the limits of liability, will include indemnity payments only.

C. Any premium credit, because of the assumption of a deductible, must be submitted to **MAIC** for rating.

D. A deductible may require the **Named Insured** to post a letter of credit or other suitable form of security.

I. MATURITY FACTORS

The following represent the maturity factors to be applied in the event a **Named Insured** is insured for less than seven (7) years with **MAIC** or an appropriate insurance carrier:

Year	Factor
1st	.250
2nd	.500
3rd	.780
4th	.925
5th	.950
6th	.975
7th	1.000

II. TAIL FACTORS

The following represent the tail factors as referenced in General Rules, Section VIII, in the event a **Named Insured** obtains an Extended Reporting Endorsement:

Year	Factor
1st	3.306
2nd	3.153
3rd	2.401
4th	2.178
5th	2.196
6th	2.183
7th	2.180

III.

Territory I Cook, Madison, St. Clair and Will Counties.

Territory II Jackson and Vermilion Counties.

Territory III Kane, Lake, McHenry and Winnebago Counties.

Territory IV Kankakee County.

Territory V Bureau, Champaign, Coles, DeKalb, DuPage, Effingham, LaSalle, Macon, Ogle and Randolph Counties.

Territory VI Grundy and Sangamon Counties.

Territory VII Remaining Counties in Illinois.

(Edition Date: 09/01/06 amended 01/01/09)

IV. The following defines the medical procedure terms parenthetically referenced in the rate pages.

A. Specified Minor Risk Procedures (SMRP)

Cardiologists who perform the specified risk procedures of assisting in surgery, insertions of cardiac pacemaker (temporary or permanent) or pericardiocentesis will be rated Cardiovascular Disease SMRP. Performance of other minor risk procedures will increase the premium charge.

B. Minor Risk Procedures (MRP)

Except as noted under Paragraph A. above, **Physicians** with nominal specialty designation/risk notation of NMRP (No Minor Risk Procedures) performing any of the following minor risk procedures will be assigned the specialty designation/risk notation of MRP.

1. Angiography/Arteriography.
2. Assisting in the performance of surgery.
3. Arterial, venous, cardiac or other diagnostic catheterization (includes insertion of cardiac pacemaker whether temporary or permanent). This does not apply to Swan-Ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel, which are covered under the specialty designation/risk notation of NMRP.
4. Cervical conization and LEEP Procedures.
5. Diagnostic/therapeutic dilation and curettage. This does not apply to induced non-spontaneous abortions.
6. Fallopian tube recanalization.
7. Interstitial hyperthermia.
8. Interventional radiology such as embolization, (including extracranial), percutaneous transluminal angioplasty, percutaneous nephrostomy and drainage procedures.
9. Intracoronary streptokinase infusion.
10. MRI-guided focused ultrasound for treatment of uterine fibroids.
11. Myocardial biopsy.
12. Obstetrical vacuum extraction.

13. Ophthalmic surgery-either extraocular only or extraocular and intraocular (includes surgery for glaucoma, cataract, retinal detachment and strabismus surgery--including Yag laser treatment for membrane opacity, laser trabeculoplasty and laser iridectomy and incision and curettage of chalazion of eyelid).

14. Percutaneous angioplasty with or without stent placement.

15. Pericardiocentesis.

16. Therapeutic radiology, deep (includes radium implants).

17. Ultrasound hyperthermia (superficial only).

18. Uncomplicated obstetrical care either prenatal (which may include amniocentesis) and post-partum only, and/or cephalic vaginal deliveries performed in a hospital which may also include episiotomy and application of low forceps only.

19. Vascular Access Procedures (primarily for dialysis) including tunneled catheter insertion, vascular access angiography, vascular access angioplasty, vascular access thrombolysis and vascular access thrombectomy.

C. Major Risk Procedures--Limited Performance (LMajRP)

Physicians performing any of the following major risk procedures shall be assigned the specialty designation/risk notation of LMajRP but only if these activities represent an incidental portion of the **Physician's** practice.

1. Obstetrical Procedures:

   Cesarean section; mid-forceps delivery; version and extraction; breech extraction; multiple gestation; VBAC; abortions, induced, non-spontaneous.

2. Orthopedic Procedures:

   Closed reduction of dislocations other than fingers, toes and shoulders; open reduction of fractures or dislocations; amputations (other than digits); any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to the fracture; any fracture of the vertebrae that is dislocated and/or involves concomitant injury to the spinal cord or other adjacent or subjacent organs due to the fracture; or orthopedic surgery including obtaining an iliac crest bone graft and open procedures on the coccyx but excluding open procedures on the rest of the spine.

3. Other major surgical procedures performed by specialists in Obstetrics, Gynecology, Orthopedic, General, Cardiac, Vascular, Plastic Surgery, etc.

D. Major Risk Procedures—Other Than Limited Performance (MajRP)

Family Practice, General Practice or other similarly rated **Physicians** performing any of the following major risk procedures where these activities represent more than an incidental portion of the **Physician's** practice will be rated similarly to the specialty which generally performs such procedures on a regular and customary basis:

1. Obstetrical Procedures:

   Cesarean section; mid-forceps delivery; version and extraction; breech extraction; multiple gestation; VBAC; abortions, induced, non-spontaneous.

2. Orthopedic Procedures:

   Closed reduction of dislocation other than fingers, toes and shoulders; open reduction of fractures or dislocations; amputations (other than digits); any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to the fracture; any fracture of the vertebrae that is dislocated and/or involves concomitant injury to the spinal cord or other adjacent or subjacent organs due to the fracture; or orthopedic surgery including obtaining an iliac crest bone graft and open procedures on the coccyx but excluding open procedures on the rest of the spine.

3. Other major surgical procedures performed by specialists of Obstetrics, Gynecology, Orthopedic, General, Cardiac, Vascular, Plastic Surgery, etc.

4. Otorhinolaryngoloqy:

   In addition, performance of elective cosmetic surgery on the head or neck will increase the premium charge.

5. General Surqeons:

   Performance of major risk procedures, as outlined above, generally attributable to other surgical specialists will not increase the premium charge provided these activities do not represent more than an incidental portion of the **Physician's** practice; if these activities do represent more than an incidental portion, the **Physician** will be rated similarly to the specialty which generally performs such procedures on a regular and customary basis.

E. Major Risk Procedures

Physicians performing any quantity of the following procedures will be rated as noted below unless such rating is increased by other provisions of this manual:

1. Gastroplasty, gastric stapling, gastric partitioning or any like surgical procedure for the treatment of morbid obesity, obesity or weight reduction, will be rated as General Surgery.

2. Temporomandibular Joint Surgery including total replacement, arthroscopy, alloplastic implants or meniscal repair via plication, will be rated as Orthopedics Without Spinal Surgery.

3. Chorionic Villi Sampling will be rated similarly to that of Obstetrical/ Gynecological Surgery.

4. Spinal Surgery, Chemonucleolysis will be rated as Orthopedics With Spinal Surgery.

5. Neurosurgery, Gamma Knife (Leskell Gamma Radiosurgical Unit) will be rated as Neurosurgery.

6. Liposuction will be rated as Plastic Surgery.

V. NEWLY PRACTICING PHYSICIAN PREMIUM DISCOUNT RULES

A. Applicable to any **Physician** who, as of the effective date of insurance with **MAIC,** is entering the practice of medicine for the first time or has been in practice for less than 48 months following:

1. Attainment of medical license;

2. Completion of residency or fellowship training including completion by an established practitioner of training in a different medical specialty in which the **Physician** intends to practice; or,

3. Completion of military service or other extended government service (e.g., National Health Service Corps etc.).

A **Physician** who is insured for "moonlighting" activity while still enrolled in a medical training program is ineligible for a premium discount under this rule.

B. The premium discount is a percentage calculated from the time a **Physician** enters medical practice and prorated within the first four (4) policy years. The applicable discount is determined by the length of time the **Physician** has been in practice as of the effective date of insurance, according to the following table:

	Time In Practice	% Of Discount	% Insured Pays
1st Practice Year	1 – 12 Months	50%	50%
2nd Practice Year	13 – 24 Months	35%	65%
3rd Practice Year	25 – 36 Months	20%	80%
4th Practice Year	37 – 48 Months	5%	95%

C. The premium discount:

1. Applies in lieu of and not in addition to the Part Time Rating Rules. A **Physician** who is eligible for rate reduction under either set of rules shall automatically be entitled to the benefit of whichever rule affords the greater premium discount. This determination will be made for each policy year until the **Physician's** eligibility for the "Newly Practicing Physician" premium discount has expired; and

2. May be superseded but not extended by the benefit of "suspended coverage" rating.

VI. PART-TIME RATING RULES

A. The following part-time categories may be applicable to a **Physician** if the criteria established in Paragraphs B or C are met:

1. **Physician** is "Retired, Not in Practice"

   a. Coverage afforded under the **Physician** Professional Liability Claims-Made Insurance Policy is limited to the occasional treatment of friends and relatives without remuneration.

   b. The premium shall be 20% of the rate applicable to the lowest specialty designation based on the **Physician's** territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

2. **Physician** whose "average weekly practice time" is not more than 10 hours per week. Exception: Not more than 12 hours per week for Emergency Department Medicine.

   a. The premium shall be 27.5% of the rate applicable to the **Physician's** specialty designation, territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

3. **Physician** whose "average weekly practice time" is not more than 21 hours per week. Exception: Not more than 24 hours per week for Emergency Department Medicine.

    a. The premium shall be 60% of the rate applicable to the **Physician's** specialty designation, territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

B. The criteria for part-time rating consideration for a **Physician** who is "Retired, Not in Practice" is as follows:

1. The **Physician** must submit a written request for part-time rating based on the **Retirement** from active practice.

2. Upon establishment of the aforementioned criteria, a **Physician** who is "Retired, Not in Practice", shall have his/her policy appropriately endorsed.

C. The criteria for part-time consideration for **Physicians** who are not retired are as follows:

1. "Average weekly practice time" as determined on the basis of the **Physician's** written representations meets the "hour per week" limitations as specified in Paragraphs A.2. or A.3 above. "Average weekly practice time" is defined as the amount of time spent each week on the following:

    a. clinical patient care;
    b. completion of patient medical records;
    c. consultations;
    d. "on-call" time in the hospital; and
    e. in-hospital activities, including hospital rounds, patient and non-patient care.

2. Any professional activity for which coverage is not desired, and which requires the issuance of an exclusionary endorsement attached to the individual **Physician's** policy with respect to such activity, shall be considered in the application of Paragraph C.1. Verification of coverage for such activity must be received by **MAIC.**

3. Notwithstanding Paragraph C.1. above, a **Physician** who schedules patient appointments more than four (4) days per week may not be considered for part-time rating. This includes all patient contact, including but not limited to in a hospital, surgi center, emergi center or other out-patient facility.

4. Upon establishment of the aforementioned criteria, the Part-Time Coverage Endorsement shall be attached to the **Physician's** policy.

D. **Physicians** with a specialty designation/risk notation of NMRP, MRP, SMRP or LMajRP, who, in addition to their specialty practice, also engage in emergency department services other than for the purpose of satisfying hospital staff privilege requirements, may be eligible for composite rating as follows:

1. For 22 hours per week or more of specialty practice and not more than 24 hours per week of emergency department services, the premium shall be the sum of 50% of the rate applicable to a specialty designation/risk notation of NMRP, MRP, SMRP or LMajRP, and 50% of the rate applicable to Emergency Medicine -- NMajS, prim. based on the **Physician's** territory and maturity year which is contained in the rate pages in Appendix I, Section I.

2. For 25 hours per week or more of emergency department services, the premium shall be 100% of the rate applicable to Emergency Medicine--NMajS. prim., the **Physician's** territory and maturity year which is contained in the rate pages in Appendix I, Section I.

VII. FREE MEDICAL CLINIC COVERAGE

A **Physician** whose sole insurable practice activity is rendering **Professional Services** in a "Free Medical Clinic" for no remuneration may be eligible for a reduced annual rate of $45 for limits of $1,000,000/$3,000,000, regardless of territory. The **Physician** shall have his/her policy amended with an endorsement. This premium cannot be lowered for any reason.

A **Physician** cannot reduce to this specialty from any other rating classification identified in this manual. No prior acts coverage is afforded under this classification for the rendering of **Professional Services** not in a "Free Medical Clinic".

Upon termination of the policy, the **Physician** will be eligible to purchase an Extended Reporting Endorsement as outlined in General Rules, Section VIII, Paragraph C. except that the premium will be waived for a **Physician** whose sole insurable practice activity was rendering **Professional Services** in a "Free Medical Clinic".

VIII. SUSPENDED COVERAGE RULES

These rules apply to a **Physician** who temporarily ceases to practice medicine ("leave of absence" or "inactive practice") due to voluntary interruption of practice (e.g., vacation, travel, continuing education, research, etc.), or an involuntary interruption of practice (e.g., incapacitating illness or **Disability**, other health reasons, including pregnancy, etc.).

A. If leave of absence is one (1) month or less, no premium reduction shall be given.

B. If the leave of absence is more than one (1) month but does not exceed one (1) year:

1. The prorated premium for the suspended period of time shall be 25% of the rate applicable to the **Physician's** specialty designation, territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

2. The suspended coverage rate reduction does not apply to any other charges used in developing the policy premium (e.g., any scheduled rating credit or debits, additional **Insureds** etc.), nor, does it estop the passage of time applicable to the Newly Practicing Physician Premium Discount.

3. A Suspended Coverage Endorsement shall be issued.

C. Suspended coverage is not available for periods of time equal to one (1) year or more.

D. Whenever a **Physician** requests cancellation of a policy because suspended coverage is not available or for any other reason, a new policy will not be issued until three (3) months after the cancellation date and will be subject to re-underwriting, including the required purchase of an Extended Reporting Endorsement at the time of cancellation.

IX. LOCUM TENENS (ADDITIONAL INSURED)

A. When a **Physician** (the "Locum Tenens") is temporarily substituting for an **Insured Physician** and the Locum Tenens does not have professional liability insurance with limits of $1,000,000/$3,000,000 which covers him/her for such substituting activities, the Locum Tenens can be added as an additional **Insured** by means of endorsement, the use of which is governed by the rules set forth below.

B. The premium shall be the rate applicable to the Locum Tenens' specialty designation and the **Insured Physician's** territory and maturity year multiplied by the applicable percentage as specified below in the accompanying chart:

Number Of Days Expected Substitution	Percentage Applied To Installment Premium Amount
1 to 30 days	0%
31 to 60 days	35%
61 to 90 days	65%

C. The following rules are applicable to Locum Tenens coverage:

1. Locum Tenens coverage can only be provided for a maximum of 90 consecutive days. EXCEPTION: If the Locum Tenens is substituting in a recognized emergency department of a licensed healthcare institution, a maximum coverage of only 30 consecutive days will be allowed.

2. The Locum Tenens may not be insured to substitute for more than one **Insured Physician** during the same period of time.

3. Each **Insured Physician** is required to pay the appropriate premium when adding a Locum Tenens to his/her policy, regardless of whether another **Insured Physician** is being charged premium for covering the substitute services of the same Locum Tenens during a different time period.

4. There is no need to purchase an Extended Reporting Endorsement upon discontinuation of Locum Tenens coverage. Coverage for future reported **Claims/Suits** continues for the **Policy Period** and pursuant any Extended Reporting Endorsement purchased by the **Named Insured.**

5. A separate premium charge shall be made for each Locum Tenens.

6. If the period of coverage for the Locum Tenens is continuous and begins prior to renewal and extends through and beyond renewal, the premium charge shall be based on the rates in effect prior to said renewal.

7. If the period of coverage for the Locum Tenens is a discrete series of days which begins prior to and extends through and beyond renewal, a separate premium charge shall be made for:

   a. the period prior to renewal; and,
   b. the period on or after renewal.

X. LOSS-FREE DISCOUNT

Physicians may qualify for a discount in premium when renewing a policy based on the following criteria:

A. The **Physician** must have been insured continuously during the experience period. See chart below.

B. The **Physician** must have incurred no indemnity payments (i.e., no indemnity payment made) during the experience period.

C. Experience Periods and Applicable Discounts:

Years	Discount Applied
3	3%
4	6%
5	8%
6	10%
7	12%
8	17%
9	18%
10	19%
11+	19.5%

D. Initial applicants for insurance may qualify for a loss-free discount except that the experience period will be measured annually from the applicant's **Retroactive Date**. Proof of loss-free must be submitted to **MAIC** from the applicant's prior carrier(s).

E. The Loss Free Discount may be applied to all medical specialties except "**Physician**, Treating Patients in Free Medical Clinic" and does not apply to FTE Per Visit Rating.

XI. SCHEDULED RATING CREDITS/DEBITS

The following credits/debits may be applied at the discretion of MAIC in accordance with the following procedures:

A. A maximum Scheduled Rating Credit/Debit of +/- 25% may be applied according to the following schedule:

	Range		
	Credit		**Debit**
Specialty Classification	10%	to	10%
Patient Rapport	5%	to	5%
Risk Management Program/Quality of Care	15%	to	15%
Professional Skills and Competency	20%	to	20%

B. The combination of scheduled rating and Loss-Free Discount may not exceed a 44.5% credit.

XII. RISK MANAGEMENT EDUCATIONAL DISCOUNT PROGRAM

Physicians have the opportunity to qualify for a renewal discount by participating in **MAIC**-approved risk management programs. Discounts earned are applicable only to the renewal term immediately following the **Policy Period** in which they are earned and do not apply to any future renewal periods. A maximum discount of 8% can be earned per **Physician** from the following two (2) risk management components:

A. On-line risk management courses offered by **MAIC**:

A 1% discount will be earned for the completion of each on-line course for a maximum discount of 4% per **Policy Period**.

B. Participation in a **MAIC**-approved risk management or **Physician** office meeting or education or in-service program as may be made available at **MAIC's** discretion. The maximum discount that can be earned from this component of the plan is 4% and is based on:

1. 1% discount for every one (1) hour of participation in an approved meeting or program.

2. Discounts will be awarded only after attendance evidenced by a **MAIC**-awarded certificate of completion.

3. No fractional percentages will be awarded and numbers will be rounded down; e.g. 3.5 hours of participation equals a 3% discount.

Discounts earned are applicable only to the renewal term immediately following the policy period in which they are earned and do not apply to any future renewal periods.

Discounts for per visit rated physicians will be individually assessed and may not be eligible for the full 8%.

XIII. LOSS EXPERIENCE CALCULATION

The Loss Experience Calculation will be applied to FTE Per Visit Rating and will be applied in lieu of Loss-Free Discount.

Loss experience for both existing and new business with at least four years of practice experience will be taken into consideration in accordance with the following formula:

((Actual Loss x Credibility) / Expected Losses)) + (1 - Credibility) = Credit/Debit %

Maximum debit/credit for Loss Experience Calculation will be +/- 25%.

I. MEDICAL CORPORATION

A. ELIGIBILITY

To be eligible for coverage as a **Medical Corporation,** the **Medical Corporation** must conduct a medical business that is owned and operated by **Insured Physicians** for the purpose of providing patient services. Such services must be related to the **Physician** owners' medical practice specialty or professional qualifications and be rendered by the **Physician** owners or other qualified **Physicians** and/or **Paramedical Employees** employed by the **Physician** owners in the name of the **Medical Corporation**.

B. INSURABILITY

Determination of insurability is made on the basis of a completed insurance application form. If the medical business to be insured is otherwise eligible, it is mandatory that all **Physician** partners, shareholders, officers, directors and employees of the partnership or **Medical Corporation** be individually insured with **MAIC** for limits of liability at least equal to those desired by the partnership or **Medical Corporation**.

Exception: The requirements for individual insurance with **MAIC** may be waived, at **MAIC's** discretion, under circumstances where a shareholder, officer, director or employed **Physician** has no need for or cannot obtain personal professional liability insurance with **MAIC** (e.g., a retired **Physician**, a **Physician** on leave of absence, a **Physician** not primarily practicing in the State of Illinois, a **Physician** declined for underwriting reasons, etc.). In such cases, the policy issued to the **Medical Corporation** by **MAIC** may be endorsed to exclude liability arising out of the acts or omissions of any such uninsured **Physician**.

C. RATES

1. Insurance for any **Medical Corporation** owned solely by a **Named Insured,** is provided through the **MAIC** Physician Professional Liability Insurance Policy without additional premium charge.

2. **Medical Corporations** not owned solely by a **Named Insured** are subject to the following standard premium charges:

    a. The sum of 21% of the premium that would be charged for each officer's, director's, shareholder's, employee's or independent contractor's individual policy premium (without regard to any scheduled rating credit or debit), subject to a maximum of the average of the five highest rated **Physician** officer's, director's, shareholder's, employee's or independent contractor's individual policy premium as calculated above; plus,

    b. The appropriate per person rate for each Paramedical Employee whose rate appears on the rate pages contained in Appendix I, Section II; plus,

c. Any established scheduled rating credit or debit.

3. Upon cancellation or non-renewal of a **Medical Corporation** policy, an Extended Reporting Endorsement may be purchased as described in General Rules, Section VIII. A **Medical Corporation** Extended Reporting Period premium is not subject to any minimum or maximum.

4. The standard premium charges do not apply to abortion clinics, multi-phasic diagnostic centers, surgi centers (ambulatory care centers), weight control clinics, 24 hour emergi centers and any other medical businesses with unique or unusual exposure conditions not governed or contemplated by the rules and standard premium charges contained herein. These types of medical businesses must be submitted for rating.

MEDICAL ALLIANCE INSURANCE COMPANY

MANUAL OF
CLAIMS-MADE
RULES AND RATES

(Edition Date: 09/01/06)

MEDICAL ALLIANCE INSURANCE COMPANY
PHYSICIAN PROFESSIONAL LIABILITY
CLAIMS-MADE INSURANCE POLICY

MANUAL OF RULES AND RATES

TABLE OF CONTENTS

GENERAL RULES		**Page**
I.	General Instructions	4
II.	Policy Period	5
III.	Scope of Coverage	5
IV.	Persons Insured	5
V.	General Definitions	5
VI.	Limits of Liability	5
VII.	Rates and Premium Calculation	6 - 8
VIII.	Cancellation / Non-Renewal	8 - 11~~10~~
IX.	Additional Interests	11
X.	Underwriting Procedure	12 - 13~~11 - 12~~
XI.	Physician Specialty	13~~12~~
XII.	Supplementary Rules	14~~13~~
XIII.	Deductibles	14 - 15~~13 - 14~~

(Cont'd.)

MANUAL OF RULES AND RATES

TABLE OF CONTENTS

		Page
APPENDIX I		
I.	Annual Claims-Made Rates	1 - 14
II.	Paramedical Employees Rates	15 - 16
III.	Per Visit Rates	17
APPENDIX II		
I.	Maturity Year Factors	1
II.	Tail Factors	1
III.	Territories	1
IV.	Medical Procedure Definitions	2 - 5
V.	Newly Practicing Physician Premium Discount Rules	5 - 6
VI.	Part-Time Rating Rules	6 - 8
VII.	Free Medical Clinic Coverage	8
VIII.	Suspended Coverage Rules	8 - 9
IX.	Locum Tenens (Additional Insured)	9 - 10
X.	Loss-Free Discount	10 - 11~~10~~
XI.	Scheduled Rating Credits/Debits	11
XII.	Risk Management Educational Discount Program	12
XIII.	Loss Experience Calculation	12
APPENDIX III		
I.	Medical Corporation	1 - 2

Formatted: Font: Not Bold

Formatted: Font: Not Bold

MEDICAL ALLIANCE INSURANCE COMPANY
PHYSICIAN PROFESSIONAL LIABILITY
CLAIMS MADE INSURANCE MANUAL

GENERAL RULES

I. GENERAL INSTRUCTIONS

This manual contains the rules and rates governing the underwriting of professional liability insurance for **Physicians**, **Medical Corporations** and **Paramedical Employees** written on a claims-made policy form.

Additional exposure risks for which coverage is provided on or after the effective date of this manual, either by endorsement of outstanding policies or by the issuance of separate policies, shall be written on the basis of the rates and rules in effect at the time the coverage is provided.

The following requirements shall be observed in the preparation of policies of insurance covered by this manual:

A. On policies issued to a **Physician**, the **Physician** shall be identified as the **Named Insured** on the Declarations Page by name, rating medical specialty and rating code number.

B. On policies issued to **Medical Corporations** whose qualification for said policy is established in Appendix III, the **Medical Corporation** shall be identified as the **Named Insured** on the Declarations Page by its legal name.

C. On policies issued to a group of **Physicians** not associated with a **Medical Corporation**, a non-covered **Named Insured** for the purposes of facilitating the issuance, administration and payment of the policy shall be identified on the Declarations Page.

D. Additional **Insureds** and additional **Named Insureds** (who may be Doctors of Medicine, Doctors of Osteopathy, **Paramedical Employees** or **Medical Corporations**) shall be identified on attaching endorsements either by name (in the case of **Physicians** and a sole shareholder **Medical Corporation**) or by name or number (in the case of designated **Paramedical Employees**).

E. When applicable, policies shall be endorsed to acknowledge any reported exceptions to the representations and warranties stipulated on the Declarations Page.

F. Once a policy has been issued, any changes thereto shall be accomplished by means of endorsement(s).

II. POLICY PERIOD

A. Policies are written for the period of time specified on the Declarations Page upon payment of premium and expire upon cancellation, non-renewal or renewal.

B. Policies are generally written for a twelve (12) month period beginning on the policy effective date.

C. Any policy written for at least a twelve (12) month period may, upon the **Named Insured's** request and approval by **MAIC**, be extended up to a maximum of ninety (90) additional days. The aggregate limit of liability as described in Section VI. shall apply to the sum of the original **Policy Period** plus any extension.

III. SCOPE OF COVERAGE

For details of coverage and exclusions, refer to standard policy.

IV. PERSONS INSURED

For persons insured, refer to standard policy.

V. GENERAL DEFINITIONS

For general definitions, refer to standard policy.

VI. LIMITS OF LIABILITY

Manual rates and minimum premiums are calculated to provide limits of $1,000,000 "Each Person" and a **Policy Period** aggregate of $3,000,000. Unless modified by endorsement, the inclusion of more than one **Insured** under a policy shall not operate to increase **MAIC's** limits of liability.

MAIC may, at its discretion, increase the policy aggregate. The "Each Person" limit may be obtained only in the amount of $1,000,000 with a corresponding annual aggregate of $3,000,000 applied to each **Named Insured**, or an aggregate limit may be shared by each **Named Insured** with the amount being determined by the number of exposures in the group as follows:

Number of Exposures *	Policy Aggregate
2	5M
3	8M
4	10M
5	15M
6	16M
7	18M
8	20M
9	22M
10 – 19	25M
20 – 39	40M
40 - 59	55M
60 – 79	70M
80 – 99	85M

*** For each additional 20 exposures, increase the aggregate by $15M.**

VII. RATES AND PREMIUM CALCULATION

A. RATES

Annual and Extended Reporting Endorsement premiums applicable to **Physicians** for each specialty, territory and maturity year appear on the rate pages contained in Appendix I, Section I.

Premiums and rate categories for **Paramedical Employees** (who may be added by endorsement as either additional **Named Insureds** or additional **Insureds** on the standard policy) appear on the rate pages contained in Appendix I, Section II.

B. (a) RATED RISKS

Every risk described in the rate pages contained in Appendix I, Section II for which the symbol (a) appears in lieu of a specific rating designation and any other risk, risk procedure or technique not otherwise identified or defined in the appendices forming a part of this manual, shall be submitted to **MAIC** for rating.

C. CALCULATION OF PREMIUM

Subject to Paragraph E. below, the premium shall be determined on the basis of the units of exposure existing at policy inception and shall be calculated in accordance with the applicable rates and rules contained or referenced in this manual. A premium involving $.50 or more shall be rounded to the next higher whole dollar. Interim premium adjustments including endorsements shall be calculated pro rata.

D. QUARTERLY INSTALLMENT OPTION

The developed premium is billed on a quarterly basis; 34% prior to policy issuance and 22% prior to the start of each subsequent three (3) month period, and shall be rounded to the nearest whole dollar. There are no interest charges or installment fees assessed. Any additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

E. MINIMUM PREMIUM RULE

Except as provided in Appendix II, Section VII, no Professional Liability Claims-Made Insurance Policy may be issued for less than a premium charge of $400 per year.

F. MATURITY YEAR

Each **Named Insured** shall, each **Policy Period**, have a designated maturity year. The measurement of the maturity year begins on the **Named Insured's Retroactive Date** and advances each subsequent year thereafter until maturity is achieved for those policies that have been issued for six (6) months or more. In the event the policy has been issued for less than six (6) months, the maturity year does not advance. See Appendix II, Section I for maturity factors.

G. FULL TIME EQUIVALENT (FTE) AND PER VISIT RATING

1. FTE/Per Visit rating is based on a certain identifiable pricing mechanism (i.e., "per-patient encounters", "per procedure", "total revenues" or "total hours") in which to assess a premium charge to a **Medical Corporation**.

2. FTE/Per Visit premium is not subject to a premium reduction because of:

   a. Suspended Coverage;
   b. Newly Practicing **Physician** Discount; or
   c. Part-Time Rating.

3. See the rate pages contained in Appendix I, Section III. for Per Visit rates.

4. FTE premium is based on the full-time mature rate of the specialty presented.

VIII. CANCELLATION / NON-RENEWAL

A. BY MAIC

The earned premium shall be determined on a pro rata basis by multiplying the number of units of exposure for the period the policy was in force by the applicable rates.

B. BY THE NAMED INSURED

The earned premium shall be determined as the difference between written and return premium. Return premium will be calculated at 90% of pro rata. The earned premium so calculated shall also be subject to the Minimum Premium Rule in Section VII, Paragraph D. If the **Physician** requests cancellation (written request from **Named Insured** required), reinstatement may not take effect until three (3) months after the cancellation date and will be subject to re-underwriting including the required purchase of an Extended Reporting Endorsement at the time of cancellation. If cancellation is due to death, **Retirement** or **Disability**, the earned premium shall be calculated on a pro rata basis.

C. EXTENDED REPORTING ENDORSEMENT

Refer to Appendix II, Section II for the tail factors to be applied to the annual expiring premium for the purchase of an Extended Reporting Endorsement. Said endorsement may be purchased upon policy termination or upon coverage termination of a **Named Insured** because of severance of the relationship between an additional **Named Insured** and the **Named Insured**. Either the **Named Insured** or the additional **Named Insured** may purchase an Extended Reporting Endorsement on behalf of the additional **Named Insured.**

The purchase of an Extended Reporting Endorsement is subject to the terms and conditions specified in the standard policy. The Extended Reporting Endorsement premium for an individual **Named Insured** is subject to the **Named Insured's** specialty and territory in effect as of the policy termination date.

The Extended Reporting Endorsement premium for a **Medical Corporation** shall be the sum of all applicable individual Extended Reporting Endorsement premiums and any **Medical Corporation** Extended Reporting Endorsement premium as appropriate.

1. **Individual Named Insured**

   Manual Rate (7th Year Rate based upon territory and specialty)

   X Maturity Year Factor

   = Annual Base Premium

   X Part Time Factor (if applicable),

   or

   X Newly Practicing Physician Discount Factor (if applicable),
   (use whichever applicable factor above would provide the greatest discount)

   = Annual Adjusted Base Premium

   - Loss Free Discount (if applicable, Loss Free Discount Factor x Annual Adjusted Base Premium)

   = Annual Discounted Premium (net of loss free discount)

   X Tail Factor

   = Extended Reporting Endorsement Premium

   If the **Named Insured** is on suspended coverage at the date of policy cancellation, the rating factors in effect before the suspended coverage will be used.

2. **Medical Corporation**

   To determine the Extended Reporting Endorsement premium for a **Medical Corporation**, the individual **Physician** premiums that have a premium bearing relationship to the corporation are used. The premium is computed as follows:

   a. For **Medical Corporations** with four or less **Physicians** with premium bearing relationships:

      Using the individual **Physician** rating method, multiply the annual adjusted base premium of each individual **Physician** by a factor of .21 (21%). Then add these amounts together to determine an annual premium.

b. For **Medical Corporations** with five or more **Physicians** with premium bearing relationships:

Determine the five highest rated **Physicians** based upon their annual adjusted base premiums. Add these annual adjusted base premiums together and divide by 5.

= Annual Base Premium

X Tail Factor

= Extended Reporting Endorsement Premium

If a **Medical Corporation** is rated on an auditable premium basis, the annual base premium is determined by multiplying the per exposure rate by the number of exposures. The tail factor is applied to the annual base premium.

c. If **Paramedical Employees** are covered under the policy, add the sum of the individual **Paramedical Employee** premiums to the developed **Medical Corporation** annual base premium before applying the tail factor.

3. All premiums for the Extended Reporting Endorsement are payable as of the due date shown on the Extended Reporting Endorsement invoice. Any such premium not paid as of the due date shall be in default and shall be grounds for not issuing or for canceling the Extended Reporting Endorsement. Any premium received after the due date shall be refunded within ten (10) business days.

4. A **Named Insured** may be granted an Extended Reporting Period without cost in the event of death or **Disability**.

A **Named Insured** who is a **Physician** or **Paramedical Employee** (separate limits) **may** obtain an Extended Reporting Endorsement at no cost or at reduced cost in the event of **Retirement** (as defined in the policy). Coverage with previous claims-made carriers may, at MAIC's option, be substituted in lieu of **MAIC** coverage so long as the **Physician** or **Paramedical Employee** (separate limits) is insured with **MAIC** for at least one year prior to requesting the Extended Reporting Endorsement. Waiver of the full premium for an Extended Reporting Endorsement based on **Retirement** will be granted only once to a **Physician** or **Paramedical Employee** (separate limits).

A credit toward the purchase of the Extended Reporting Endorsement is computed as follows:

a. one-sixtieth (1/60) of the premium for each full month the retiring **Physician** or **Paramedical Employee** (separate limits) has had consecutive coverage with **MAIC** for up to a total credit of 100% if the **Physician** or **Paramedical Employee** (separate limits) has attained the age of fifty-five at **Retirement**; or

Formatted: Font: Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Font: Not Bold

b. one one-hundred twentieth (1/120) of the premium for each full month the retiring **Physician** or **Paramedical Employee** (separate limits) has had consecutive coverage with **MAIC** for up to a total credit of 100%, regardless of age of the **Physician**~~'s age~~ or **Paramedical Employee** (separate limits) at **Retirement**.

5. A **Physician** or **Paramedical Employee** (separate limits) previously granted an Extended Reporting Period without cost~~,~~ or at reduced cost because of **Retirement** may, in the future, be considered for insurance with **MAIC** under the following circumstances:

   a. Completion of an application for insurance;

   b. Reapplication after twelve (12) months;

   c. Has reported no **Claim**s or **Suits** pursuant to the Extended Reporting Endorsement; and

   d. Payment of the appropriate premium for the period the policy was either placed on suspended coverage or rated Part-Time, 20%, Retired, Not in Practice at the same, territory wand maturity year in effect at the time of termination.

6. The premium calculated in Paragraphs 1 or 2 above is subject to proration depending upon the policy termination date and the **Named Insured's** maturity year.

   a. Maturity Year One - The Extended Reporting Endorsement premium shall be computed on a pro rata basis for each day the policy has been in force and shall be rounded to the nearest whole dollar.

   b. Maturity Year Two Through Maturity Year Six - The Extended Reporting Endorsement premium shall be the sum of:

      (i). The pro rated difference between the Extended Reporting Endorsement premium at the end of the current **Policy Period** and the premium that would have been charged had the policy terminated at the end of the preceding **Policy Period**; and

      (ii). The premium that would have been charged in the preceding **Policy Period** if the policy had terminated one (1) year earlier.

   c. Maturity Year Seven - Not subject to proration.

IX. ADDITIONAL INTERESTS

The addition of coverages, persons or entities not provided for in the standard policy shall be submitted to **MAIC** for rating.

Formatted: Font: Not Bold
Formatted: Font: Not Bold
Formatted: Font: Bold
Formatted: Font: Not Bold
Formatted: Font: Not Bold

X. UNDERWRITING PROCEDURE

A. PHYSICIAN COVERAGE

1. If a **Named Insured** employs a **Physician**, all such employed **Physicians** must be insured with **MAIC**.

2. If a **Physician's** primary office practice and primary hospital practice are in different territories, the territory to be used for rating purposes shall be:

   a. For non-surgical specialties not identified in b. below, the primary office practice location is used.

   b. For surgical specialties including but not limited to those listed below and the following identified non-surgical specialties, the primary hospital location is used.

      Anesthesiology, Cardiovascular Disease (MRP), Emergency Medicine, Family Practice (Not Primarily Major Surgery), General Practice (Not Primarily Major Surgery), Ophthalmic Surgery, Pathology, Radiology.

   c. "Primary" means 51% or more of the **Physician's** total office or hospital practice time, as applicable, spent in a given territory.

3. If a **Physician** practices in two or more territories, or, if hospital-based, the **Physician** practices in two or more hospitals which are located within different territorial boundaries, the higher rated territory shall be utilized for rating purposes.

4. The premium shall be the sum of:

   a. The rate applicable to the individual **Physician's** specialty, territory and maturity year which appears on the rate pages contained in Appendix I, Section I; plus,

   b. The appropriate per person rate for each **Paramedical Employee** whose rate appears on the rate pages contained in Appendix I, Section II; plus,

   c. Any scheduled rating credit or debit.

5. In the event a **Physician's** specialty rating is reduced, no additional premium charge shall be made. However, if the **Physician** terminates the policy within twenty-four (24) months from the effective date of a specialty reduction the resulting Extended Reporting Endorsement calculation shall be made at the highest specialty designation in effect while insured by **MAIC.**

B. MEDICAL CORPORATION COVERAGE

See Appendix III.

C. PRIOR ACTS COVERAGE

1. Prior Acts Coverage is available.

2. The appropriate maturity year will be measured as described in Section VII, Paragraph F.

3. The premium for Prior Acts Coverage shall be calculated as described in Section X, Paragraphs A and B.

XI. PHYSICIAN SPECIALTY

A. **Physician** specialty assignment for rating purposes shall be made on the basis of:

1. The **Physician's** trained medical specialty. "Trained medical specialty" is defined as:

   a. Completion of a bona fide residency program by the **Physician**;

   b. Completion of a bona fide residency and fellowship program by the **Physician**; or

   c. If neither a. or b. are applicable to the **Physician's** specific circumstances, the type of medical practice engaged in by the **Physician**, and how such **Physician** is holding him/her self out to the public.

2. When applicable, performance or non-performance of medical procedures in accordance with the rules contained in this manual.

B. The initial basis of rating assignment shall be the **Physician's** trained medical specialty as described above. To the extent that the **Physician's** practice activity contemplated by the medical specialty may be increased by the performance of medical procedures not usual and customary to the trained specialty, or may be decreased by the non-performance of medical procedures that are usual and customary to the trained medical specialty, the **Physician's** rating assignment may be adjusted higher or lower as specified in Appendix II, Section IV.

C. The **Physician** specialty rating schedules and rules of this manual do not apply to **Physicians** in active United States Military Service or to the government practice activity of **Physicians** employed on a full or part-time basis by any government agency, institution or facility, other than a medical school or student health center.

Physicians and **Medical Corporations** rendering or furnishing medical services within any government-owned or operated institution or facility (except a medical school, a facility owned or operated by a medical school or a student health center) on a fee-for-service (independent contractor) basis shall be subject to (a) rating.

XII. SUPPLEMENTARY RULES

A. SPECIAL RULES GOVERNING PHYSICIAN RATING

1. **NEWLY PRACTICING PHYSICIAN PREMIUM DISCOUNT RULE**

   See Appendix II, Section V.

2. **PART-TIME RATING RULE**

   See Appendix II, Section VI.

3. **SUSPENDED COVERAGE RULE**

   See Appendix II, Section VIII.

4. **CHANGE IN SPECIALTY MINIMUM DURATION RULE**

   Physicians who voluntarily request either a decrease or increase in specialty assignment may not obtain a further change in specialty assignment until a period of three (3) months has elapsed. This rule shall not apply when it conflicts with any other rule in this manual.

5. **LOSS-FREE DISCOUNT**

   Physicians with no indemnity payments over a given experience period may qualify for a premium discount. See Appendix II, Section X.

B. RESTRICTIVE ENDORSEMENT RULE

Whenever a restrictive endorsement is attached to the policy of an employed **Physician, Paramedical Employee** or a **Physician** who is either an officer, director or shareholder of a **Medical Corporation**, a comparable endorsement shall be attached to the respective employer's policy if such employer is insured by **MAIC**. Such endorsement shall serve to limit the liability otherwise afforded under such policies, for the acts and omissions of the **Insured** whose individual coverage is restricted, if the **Claim** or **Suit** arises out of the excluded activity.

XIII. DEDUCTIBLES

A. A deductible may be available to **Named Insureds** who either desire to share in their losses in return for premium savings or have demonstrated a significant adverse loss profile necessitating that they take a primary role in the management of their risk.

B. A deductible requires the **Named Insured** to share financially in each and every **Claim**. Varying amounts may be arranged depending on the financial and risk management expertise of the **Named Insured**. The deductible, which is inside the limits of liability, will include indemnity payments only.

C. Any premium credit, because of the assumption of a deductible, must be submitted to **MAIC** for rating.

D. A deductible may require the **Named Insured** to post a letter of credit or other suitable form of security.

APPENDIX II

I. MATURITY FACTORS

The following represent the maturity factors to be applied in the event a **Named Insured** is insured for less than seven (7) years with **MAIC** or an appropriate insurance carrier:

Year	Factor
1st	.250
2nd	.500
3rd	.780
4th	.925
5th	.950
6th	.975
7th	1.000

II. TAIL FACTORS

The following represent the tail factors as referenced in General Rules, Section VIII, in the event a **Named Insured** obtains an Extended Reporting Endorsement:

Year	Factor
1st	3.306
2nd	3.153
3rd	2.401
4th	2.178
5th	2.196
6th	2.183
7th	2.180

III. Territory I

Cook, Madison, St. Clair and Will Counties.

Territory II Jackson and Vermilion Counties.

Territory III Kane, Lake, McHenry and Winnebago Counties.

Territory IV Kankakee County.

Territory V Bureau, Champaign, Coles, DeKalb, DuPage, Effingham, LaSalle, Macon, Ogle and Randolph Counties.

Territory VI Grundy and Sangamon Counties.

Territory VII Remaining Counties in Illinois.

IV. The following defines the medical procedure terms parenthetically referenced in the rate pages.

A. Specified Minor Risk Procedures (SMRP)

Cardiologists who perform the specified risk procedures of assisting in surgery, insertions of cardiac pacemaker (temporary or permanent) or pericardiocentesis will be rated Cardiovascular Disease SMRP. Performance of other minor risk procedures will increase the premium charge.

B. Minor Risk Procedures (MRP)

Except as noted under Paragraph A. above, **Physicians** with nominal specialty designation/risk notation of NMRP (No Minor Risk Procedures) performing any of the following minor risk procedures will be assigned the specialty designation/risk notation of MRP.

1. Angiography/Arteriography.
2. Assisting in the performance of surgery.
3. Arterial, venous, cardiac or other diagnostic catheterization (includes insertion of cardiac pacemaker whether temporary or permanent). This does not apply to Swan-Ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel, which are covered under the specialty designation/risk notation of NMRP.
4. Cervical conization and LEEP Procedures.
5. Diagnostic/therapeutic dilation and curettage. This does not apply to induced non-spontaneous abortions.
6. Fallopian tube recanalization.
7. Interstitial hyperthermia.
8. Interventional radiology such as embolization, (including extracranial), percutaneous transluminal angioplasty, percutaneous nephrostomy and drainage procedures.
9. Intracoronary streptokinase infusion.
10. MRI-guided focused ultrasound for treatment of uterine fibroids.
11. Myocardial biopsy.
12. Obstetrical vacuum extraction.

13. Ophthalmic surgery-either extraocular only or extraocular and intraocular (includes surgery for glaucoma, cataract, retinal detachment and strabismus surgery--including Yag laser treatment for membrane opacity, laser trabeculoplasty and laser iridectomy and incision and curettage of chalazion of eyelid).

14. Percutaneous angioplasty with or without stent placement.

15. Pericardiocentesis.

16. Therapeutic radiology, deep (includes radium implants).

17. Ultrasound hyperthermia (superficial only).

18. Uncomplicated obstetrical care either prenatal (which may include amniocentesis) and post-partum only, and/or cephalic vaginal deliveries performed in a hospital which may also include episiotomy and application of low forceps only.

19. Vascular Access Procedures (primarily for dialysis) including tunneled catheter insertion, vascular access angiography, vascular access angioplasty, vascular access thrombolysis and vascular access thrombectomy.

C. Major Risk Procedures--Limited Performance (LMajRP)

Physicians performing any of the following major risk procedures shall be assigned the specialty designation/risk notation of LMajRP but only if these activities represent an incidental portion of the **Physician's** practice.

1. Obstetrical Procedures:

   Cesarean section; mid-forceps delivery; version and extraction; breech extraction; multiple gestation; VBAC; abortions, induced, non-spontaneous.

2. Orthopedic Procedures:

   Closed reduction of dislocations other than fingers, toes and shoulders; open reduction of fractures or dislocations; amputations (other than digits); any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to the fracture; any fracture of the vertebrae that is dislocated and/or involves concomitant injury to the spinal cord or other adjacent or subjacent organs due to the fracture; or orthopedic surgery including obtaining an iliac crest bone graft and open procedures on the coccyx but excluding open procedures on the rest of the spine.

3. Other major surgical procedures performed by specialists in Obstetrics, Gynecology, Orthopedic, General, Cardiac, Vascular, Plastic Surgery, etc.

D. Major Risk Procedures—Other Than Limited Performance (MajRP)

Family Practice, General Practice or other similarly rated **Physicians** performing any of the following major risk procedures where these activities represent more than an incidental portion of the **Physician's** practice will be rated similarly to the specialty which generally performs such procedures on a regular and customary basis:

1. Obstetrical Procedures:

   Cesarean section; mid-forceps delivery; version and extraction; breech extraction; multiple gestation; VBAC; abortions, induced, non-spontaneous.

2. Orthopedic Procedures:

   Closed reduction of dislocation other than fingers, toes and shoulders; open reduction of fractures or dislocations; amputations (other than digits); any fracture of the pelvis that is displaced and/or involves concomitant injury to adjacent or subjacent organs due to the fracture; any fracture of the vertebrae that is dislocated and/or involves concomitant injury to the spinal cord or other adjacent or subjacent organs due to the fracture; or orthopedic surgery including obtaining an iliac crest bone graft and open procedures on the coccyx but excluding open procedures on the rest of the spine.

3. Other major surgical procedures performed by specialists of Obstetrics, Gynecology, Orthopedic, General, Cardiac, Vascular, Plastic Surgery, etc.

4. Otorhinolaryngoloqy:

   In addition, performance of elective cosmetic surgery on the head or neck will increase the premium charge.

5. General Surqeons:

   Performance of major risk procedures, as outlined above, generally attributable to other surgical specialists will not increase the premium charge provided these activities do not represent more than an incidental portion of the **Physician's** practice; if these activities do represent more than an incidental portion, the **Physician** will be rated similarly to the specialty which generally performs such procedures on a regular and customary basis.

E. Major Risk Procedures

Physicians performing any quantity of the following procedures will be rated as noted below unless such rating is increased by other provisions of this manual:

1. Gastroplasty, gastric stapling, gastric partitioning or any like surgical procedure for the treatment of morbid obesity, obesity or weight reduction, will be rated as General Surgery.

2. Temporomandibular Joint Surgery including total replacement, arthroscopy, alloplastic implants or meniscal repair via plication, will be rated as Orthopedics Without Spinal Surgery.

3. Chorionic Villi Sampling will be rated similarly to that of Obstetrical/ Gynecological Surgery.

4. Spinal Surgery, Chemonucleolysis will be rated as Orthopedics With Spinal Surgery.

5. Neurosurgery, Gamma Knife (Leskell Gamma Radiosurgical Unit) will be rated as Neurosurgery.

6. Liposuction will be rated as Plastic Surgery.

V. NEWLY PRACTICING PHYSICIAN PREMIUM DISCOUNT RULES

A. Applicable to any **Physician** who, as of the effective date of insurance with **MAIC,** is entering the practice of medicine for the first time or has been in practice for less than 48 months following:

1. Attainment of medical license;

2. Completion of residency or fellowship training including completion by an established practitioner of training in a different medical specialty in which the **Physician** intends to practice; or,

3. Completion of military service or other extended government service (e.g., National Health Service Corps etc.).

A **Physician** who is insured for "moonlighting" activity while still enrolled in a medical training program is ineligible for a premium discount under this rule.

B. The premium discount is a percentage calculated from the time a **Physician** enters medical practice and prorated within the first four (4) policy years. The applicable discount is determined by the length of time the **Physician** has been in practice as of the effective date of insurance, according to the following table:

	Time In Practice	% Of Discount	% Insured Pays
1st Practice Year	1 – 12 Months	50%	50%
2nd Practice Year	13 – 24 Months	35%	65%
3rd Practice Year	25 – 36 Months	20%	80%
4th Practice Year	37 – 48 Months	5%	95%

C. The premium discount:

1. Applies in lieu of and not in addition to the Part Time Rating Rules. A **Physician** who is eligible for rate reduction under either set of rules shall automatically be entitled to the benefit of whichever rule affords the greater premium discount. This determination will be made for each policy year until the **Physician's** eligibility for the "Newly Practicing Physician" premium discount has expired; and

2. May be superseded but not extended by the benefit of "suspended coverage" rating.

VI. PART-TIME RATING RULES

A. The following part-time categories may be applicable to a **Physician** if the criteria established in Paragraphs B or C are met:

1. **Physician** is "Retired, Not in Practice"

   a. Coverage afforded under the **Physician** Professional Liability Claims-Made Insurance Policy is limited to the occasional treatment of friends and relatives without remuneration.

   b. The premium shall be 20% of the rate applicable to the lowest specialty designation based on the **Physician's** territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

2. **Physician** whose "average weekly practice time" is not more than 10 hours per week. Exception: Not more than 12 hours per week for Emergency Department Medicine.

   a. The premium shall be 27.5% of the rate applicable to the **Physician's** specialty designation, territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

3. **Physician** whose "average weekly practice time" is not more than 21 hours per week. Exception: Not more than 24 hours per week for Emergency Department Medicine**.**

    a. The premium shall be 60% of the rate applicable to the **Physician's** specialty designation, territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

B. The criteria for part-time rating consideration for a **Physician** who is "Retired, Not in Practice" is as follows:

1. The **Physician** must submit a written request for part-time rating based on the **Retirement** from active practice.

2. Upon establishment of the aforementioned criteria, a **Physician** who is "Retired, Not in Practice", shall have his/her policy appropriately endorsed.

C. The criteria for part-time consideration for **Physicians** who are not retired are as follows:

1. "Average weekly practice time" as determined on the basis of the **Physician's** written representations meets the "hour per week" limitations as specified in Paragraphs A.2. or A.3 above. "Average weekly practice time" is defined as the amount of time spent each week on the following:

    a. clinical patient care;
    b. completion of patient medical records;
    c. consultations;
    d. "on-call" time in the hospital; and
    e. in-hospital activities, including hospital rounds, patient and non-patient care.

2. Any professional activity for which coverage is not desired, and which requires the issuance of an exclusionary endorsement attached to the individual **Physician's** policy with respect to such activity, shall be considered in the application of Paragraph C.1. Verification of coverage for such activity must be received by **MAIC.**

3. Notwithstanding Paragraph C.1. above, a **Physician** who schedules patient appointments more than four (4) days per week may not be considered for part-time rating. This includes all patient contact, including but not limited to in a hospital, surgi center, emergi center or other out-patient facility.

4. Upon establishment of the aforementioned criteria, the Part-Time Coverage Endorsement shall be attached to the **Physician's** policy.

D. **Physicians** with a specialty designation/risk notation of NMRP, MRP, SMRP or LMajRP, who, in addition to their specialty practice, also engage in emergency department services other than for the purpose of satisfying hospital staff privilege requirements, may be eligible for composite rating as follows:

1. For 22 hours per week or more of specialty practice and not more than 24 hours per week of emergency department services, the premium shall be the sum of 50% of the rate applicable to a specialty designation/risk notation of NMRP, MRP, SMRP or LMajRP, and 50% of the rate applicable to Emergency Medicine -- NMajS, prim. based on the **Physician's** territory and maturity year which is contained in the rate pages in Appendix I, Section I.

2. For 25 hours per week or more of emergency department services, the premium shall be 100% of the rate applicable to Emergency Medicine--NMajS. prim., the **Physician's** territory and maturity year which is contained in the rate pages in Appendix I, Section I.

VII. FREE MEDICAL CLINIC COVERAGE

A **Physician** whose sole insurable practice activity is rendering **Professional Services** in a "Free Medical Clinic" for no remuneration may be eligible for a reduced annual rate of $45 for limits of $1,000,000/$3,000,000, regardless of territory. The **Physician** shall have his/her policy amended with an endorsement. This premium cannot be lowered for any reason.

A **Physician** cannot reduce to this specialty from any other rating classification identified in this manual. No prior acts coverage is afforded under this classification for the rendering of **Professional Services** not in a "Free Medical Clinic".

Upon termination of the policy, the **Physician** will be eligible to purchase an Extended Reporting Endorsement as outlined in General Rules, Section VIII, Paragraph C. except that the premium will be waived for a **Physician** whose sole insurable practice activity was rendering **Professional Services** in a "Free Medical Clinic".

VIII. SUSPENDED COVERAGE RULES

These rules apply to a **Physician** who temporarily ceases to practice medicine ("leave of absence" or "inactive practice") due to voluntary interruption of practice (e.g., vacation, travel, continuing education, research, etc.), or an involuntary interruption of practice (e.g., incapacitating illness or **Disability**, other health reasons, including pregnancy, etc.).

A. If leave of absence is one (1) month or less, no premium reduction shall be given.

B. If the leave of absence is more than one (1) month but does not exceed one (1) year:

1. The prorated premium for the suspended period of time shall be 25% of the rate applicable to the **Physician's** specialty designation, territory and maturity year which appears on the rate pages contained in Appendix I, Section I.

2. The suspended coverage rate reduction does not apply to any other charges used in developing the policy premium (e.g., any scheduled rating credit or debits, additional **Insureds** etc.), nor, does it estop the passage of time applicable to the Newly Practicing Physician Premium Discount.

3. A Suspended Coverage Endorsement shall be issued.

C. Suspended coverage is not available for periods of time equal to one (1) year or more.

D. Whenever a **Physician** requests cancellation of a policy because suspended coverage is not available or for any other reason, a new policy will not be issued until three (3) months after the cancellation date and will be subject to re-underwriting, including the required purchase of an Extended Reporting Endorsement at the time of cancellation.

IX. LOCUM TENENS (ADDITIONAL INSURED)

A. When a **Physician** (the "Locum Tenens") is temporarily substituting for an **Insured Physician** and the Locum Tenens does not have professional liability insurance with limits of $1,000,000/$3,000,000 which covers him/her for such substituting activities, the Locum Tenens can be added as an additional **Insured** by means of endorsement, the use of which is governed by the rules set forth below.

B. The premium shall be the rate applicable to the Locum Tenens' specialty designation and the **Insured Physician's** territory and maturity year multiplied by the applicable percentage as specified below in the accompanying chart:

Number Of Days Expected Substitution	Percentage Applied To Installment Premium Amount
1 to 30 days	0%
31 to 60 days	35%
61 to 90 days	65%

C. The following rules are applicable to Locum Tenens coverage:

1. Locum Tenens coverage can only be provided for a maximum of 90 consecutive days. EXCEPTION: If the Locum Tenens is substituting in a recognized emergency department of a licensed healthcare institution, a maximum coverage of only 30 consecutive days will be allowed.

2. The Locum Tenens may not be insured to substitute for more than one **Insured Physician** during the same period of time.

3. Each **Insured Physician** is required to pay the appropriate premium when adding a Locum Tenens to his/her policy, regardless of whether another **Insured Physician** is being charged premium for covering the substitute services of the same Locum Tenens during a different time period.

4. There is no need to purchase an Extended Reporting Endorsement upon discontinuation of Locum Tenens coverage. Coverage for future reported **Claims/Suits** continues for the **Policy Period** and pursuant any Extended Reporting Endorsement purchased by the **Named Insured.**

5. A separate premium charge shall be made for each Locum Tenens.

6. If the period of coverage for the Locum Tenens is continuous and begins prior to renewal and extends through and beyond renewal, the premium charge shall be based on the rates in effect prior to said renewal.

7. If the period of coverage for the Locum Tenens is a discrete series of days which begins prior to and extends through and beyond renewal, a separate premium charge shall be made for:

   a. the period prior to renewal; and,
   b. the period on or after renewal.

X. LOSS-FREE DISCOUNT

Physicians may qualify for a discount in premium when renewing a policy based on the following criteria:

A. The **Physician** must have been insured continuously during the experience period. See chart below.

B. The **Physician** must have incurred no indemnity payments (i.e., no indemnity payment made) during the experience period.

C. Experience Periods and Applicable Discounts:

Years	Discount Applied
3	3%
4	6%
5	8%
6	10%
7	12%
8	17%
9	18%
10	19%
11+	19.5%

D. Initial applicants for insurance may qualify for a loss-free discount except that the experience period will be measured annually from the applicant's **Retroactive Date**. Proof of loss-free must be submitted to **MAIC** from the applicant's prior carrier(s).

E. The Loss Free Discount may be applied to all medical specialties except "**Physician**, Treating Patients in Free Medical Clinic" and does not apply to FTE Per Visit Rating.~~"~~

XI. SCHEDULED RATING CREDITS/DEBITS

The following credits/debits may be applied at the discretion of MAIC in accordance with the following procedures:

A. A maximum Scheduled Rating Credit/Debit of +/- 25%~~(up to a maximum of 100%) or Credit (up to a maximum of 50%)~~ may be applied according to the following schedule:

	Range		
	Credit		**Debit**
~~Loss Experience~~	~~50%~~	~~to~~	~~100%~~
Specialty Classification~~balance~~	10~~8~~%	to	10~~8~~%
Patient Rapport~~Employees selection, training, supervision, experience~~	5%	to	5%
Risk Management Program/Quality of Care	15%	to	15%
Professional Skills and Competency~~Unusual Risk Characteristics~~	20~~15~~ %	to	20~~15~~ %

B. The combination of scheduled rating and ~~the~~ Loss-Free Discount ~~in Section X above~~ may not exceed a 44.5~~69.5~~% credit.

(Edition Date: 09/01/06 amended 03/01/12)

Formatted: Font: 9 pt
Formatted Table
Formatted: Font: 11 pt
Formatted: Centered
Formatted: Centered
Formatted: Centered
Formatted: Font: 9 pt
Formatted: Centered

APPENDIX II

XII. RISK MANAGEMENT EDUCATIONAL DISCOUNT PROGRAM

Physicians have the opportunity to qualify for a renewal discount by participating in **MAIC**-approved risk management programs. Discounts earned are applicable only to the renewal term immediately following the **Policy Period** in which they are earned and do not apply to any future renewal periods. A maximum discount of 8% can be earned per **Physician** from the following two (2) risk management components:

A. On-line risk management courses offered by **MAIC**:

A 1% discount will be earned for the completion of each on-line course for a maximum discount of 4% per **Policy Period**.

B. Participation in a **MAIC**-approved risk management or **Physician** office meeting or education or in-service program as may be made available at **MAIC's** discretion. The maximum discount that can be earned from this component of the plan is 4% and is based on:

1. 1% discount for every one (1) hour of participation in an approved meeting or program.

2. Discounts will be awarded only after attendance evidenced by a **MAIC**-awarded certificate of completion.

3. No fractional percentages will be awarded and numbers will be rounded down; e.g. 3.5 hours of participation equals a 3% discount.

Discounts earned are applicable only to the renewal term immediately following the policy period in which they are earned and do not apply to any future renewal periods.

Discounts for per visit rated physicians will be individually assessed and may not be eligible for the full 8%.

XIII. LOSS EXPERIENCE CALCULATION

The Loss Experience Calculation will be applied to FTE Per Visit Rating and will be applied in lieu of Loss-Free Discount.

Loss experience for both existing and new business with at least four years of practice experience will be taken into consideration in accordance with the following formula:

((Actual Loss x Credibility) / Expected Losses)) + (1 - Credibility) = Credit/Debit %

Maximum debit/credit for Loss Experience Calculation will be +/- 25%.

Formatted: Font: Bold

Formatted: Indent: Left: 0", Tab stops: Not at 0.25"

Formatted: Indent: Left: 0", Tab stops: Not at 0.25"

Formatted: Font: Not Bold

Formatted: Tab stops: Not at 0.13" + 0.25"

Formatted: Font: Not Bold

Formatted: Indent: Left: 0", Tab stops: Not at 0.13" + 0.25" + 0.5"

Formatted: Tab stops: Not at 0.25"

Formatted: Indent: Left: 0", Tab stops: Not at 0.25"

Formatted: Left, Indent: Left: 0", Tab stops: 0.5", Left + 1.13", Left + 1.25", Left + Not at 0.81"

APPENDIX III

I. MEDICAL CORPORATION

A. ELIGIBILITY

To be eligible for coverage as a **Medical Corporation,** the **Medical Corporation** must conduct a medical business that is owned and operated by **Insured Physicians** for the purpose of providing patient services. Such services must be related to the **Physician** owners' medical practice specialty or professional qualifications and be rendered by the **Physician** owners or other qualified **Physicians** and/or **Paramedical Employees** employed by the **Physician** owners in the name of the **Medical Corporation**.

B. INSURABILITY

Determination of insurability is made on the basis of a completed insurance application form. If the medical business to be insured is otherwise eligible, it is mandatory that all **Physician** partners, shareholders, officers, directors and employees of the partnership or **Medical Corporation** be individually insured with **MAIC** for limits of liability at least equal to those desired by the partnership or **Medical Corporation**.

Exception: The requirements for individual insurance with **MAIC** may be waived, at **MAIC's** discretion, under circumstances where a shareholder, officer, director or employed **Physician** has no need for or cannot obtain personal professional liability insurance with **MAIC** (e.g., a retired **Physician**, a **Physician** on leave of absence, a **Physician** not primarily practicing in the State of Illinois, a **Physician** declined for underwriting reasons, etc.). In such cases, the policy issued to the **Medical Corporation** by **MAIC** may be endorsed to exclude liability arising out of the acts or omissions of any such uninsured **Physician**.

C. RATES

1. Insurance for any **Medical Corporation** owned solely by a **Named Insured,** is provided through the **MAIC** Physician Professional Liability Insurance Policy without additional premium charge.

2. **Medical Corporations** not owned solely by a **Named Insured** are subject to the following standard premium charges:

    a. The sum of 21% of the premium that would be charged for each officer's, director's, shareholder's, employee's or independent contractor's individual policy premium (without regard to any scheduled rating credit or debit), subject to a maximum of the average of the five highest rated **Physician** officer's, director's, shareholder's, employee's or independent contractor's individual policy premium as calculated above; plus,

    b. The appropriate per person rate for each Paramedical Employee whose rate appears on the rate pages contained in Appendix I, Section II; plus,

c. Any established scheduled rating credit or debit.

3. Upon cancellation or non-renewal of a **Medical Corporation** policy, an Extended Reporting Endorsement may be purchased as described in General Rules, Section VIII. A **Medical Corporation** Extended Reporting Period premium is not subject to any minimum or maximum.

4. The standard premium charges do not apply to abortion clinics, multi-phasic diagnostic centers, surgi centers (ambulatory care centers), weight control clinics, 24 hour emergi centers and any other medical businesses with unique or unusual exposure conditions not governed or contemplated by the rules and standard premium charges contained herein. These types of medical businesses must be submitted for rating.

MAIC SCHEDULE RATING PLAN WORKSHEET

Named Insured: Policy Name:
Policy Number: Policy Term:

A maximum Schedule Rating Credit/Debit of +/- 25% may be applied according to the following schedule. The combination of schedule rating and loss-free discount may not exceed a 44.5% credit.

	Credit (-) Maximum		Debit (+) Maximum	+/- %
Specialty Classification	10%	to	10%	

Physician's professional services and practice not consistent with other physicians in the same specialty, which could impact future loss experience.

Additional explanation:

Patient Rapport	5%	to	5%	

Length of physician service in the community or service area
Physician or group's reputation in the community and service area
Physician has multiple responsibilities including a high average weekly practice time, high number of patients per week or multiple practice locations

Additional explanation:

Risk Management Program/ Quality of Care	15%	to	15%	

Results of onsite risk management visit by company risk manager
Physician compliance with implementation of company risk management recommendations
Utilize technological advances to improve patient safety, as evaluated by company risk manager

Additional explanation:

Professional Skills/Competency	20%	to	20%	

Licensure of practice physicians including denied, revoked, or suspended
Hospital privileges including current or prior limitations thereof
Prior claim activity resulting from competency or questionable judgment
Board certification of practice physicians including lack thereof, gaps or high percentage certified
Participation in continued professional education for improvement of competency

Additional explanation:

Total

Completed By: Date Completed:

Form creation: 05/13/2009 amended 03/01/2012

Medical Alliance Insurance Company

February 29, 2012

Ms. Gayle Neuman
Illinois Department of Insurance
Property and Liability Compliance Unit
320 West Washington St.
Springfield, IL 62767-0001

Re: Medical Malpractice Rule Filing PPL-12-01-R
Medical Alliance Insurance Company
FEI #: 32-0097644
NAIC #: 11861

Dear Ms. Neuman,

Enclosed please find the above-referenced rule filing submitted on behalf of Medical Alliance Insurance Company (MAIC). This filing is to amend the claims-made rule manual currently on file.

Enclosed please find:

- Cover letter
- Explanatory memorandum
- RF-3
- Officer certification
- Actuarial certification
- Schedule rating plan worksheet (internal use only)
- Rule manual

MAIC has internal policies in place for gathering and reporting statistics to the Department of Insurance. As such, we do not report to a statistical agency.

Though this filing amends various rule pages in our claims-made manual as explained in the explanatory memorandum, we enclose the rule manual in its entirety, with the exception of Appendix I which comprises the rate pages for our program and have not been revised. Please note that this filing will be applicable to all new and renewal policies effective on and after March 1, 2012.

Thank you for your assistance on our behalf. Please advise if you should need any further clarification regarding this filing.

Sincerely,

Carolyn M. Shanahan

Carolyn M. Shanahan
Paralegal
CShanahan@ihastaff.org
Phone: 630/276-5659
Fax: 630/717-4787

Medical Alliance Insurance Company

February 27, 2012

Medical Alliance Insurance Company hereby authorizes Illinois Risk Management Services, Inc. (IRMS) to, on its behalf and in accordance with its directions, submit rate, rule, and form filings via SERFF to the state of Illinois. This authorization includes providing additional information and responding to questions regarding the filings as necessary and is deemed to be in effect until rescinded in writing.

Please direct all correspondence and inquiries related to this filing to IRMS at the following address:

IRMS
17035 W. Wisconsin Avenue, Suite 105
Brookfield, WI 53005
262-754-1600
262-754-1601 Fax

Medical Alliance Insurance Company

Edward J. Holzhauer, President

SERFF Tracking Number:	*IRMS-128131632*	*State:*	*Illinois*
Filing Company:	*Medical Alliance Insurance Company*	*State Tracking Number:*	*IRMS-128131632*
Company Tracking Number:	*PPL-12-01-R*		
TOI:	*11.0 Medical Malpractice - Claims Made/Occurrence*	*Sub-TOI:*	*11.0023 Physicians & Surgeons*
Product Name:	*Medical Malpractice Rule Filing*		
Project Name/Number:	*Medical Malpractice Rule Filing /PPL-12-01-R*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
02/29/2012	Supporting Document	Manual	03/06/2012	Manual of Claims-Made Rules and Rates.pdf